* Preventing Medical Errors for SLPs
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* SHAV Conference
* March 2024
* Introduction
* Speech Language Pathologists work in a variety of medical settings. Whether you cover the NICU, pediatric outpatient, adult or geriatric hospitals or inpatient rehab, SLPs need to identify strategies for error prevention. Health literacy, safety culture and overuse of medical language will be included in this discussion. Learn how to use simple tools for root cause analysis and how identifying the “root” can foster better patient outcomes. Case studies and examples are included.
* According to this data….
* “Preventable medical errors contribute substantially to healthcare costs, including higher health insurance costs per person expenses.”

“Medical errors cost approximately $20 billion a year.

“Medical errors in hospitals and clinics result in approximately 100,000 people dying each year.”

* Rodziewicz, Houseman and Hiskind, 2022
* Types of medical errors
* Commission error
* Omission error
* Other types of errors
* Adverse Event
* An error in surgical treatment or medical treatment that causes injury to the patient

Counted if it was preventable

* Example: not utilizing evidence based practice
* Sentinel event
* “The Joint Commission defines a "sentinel event" as “any unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof...The phrase 'or the risk thereof' includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome.” (The Joint Commission, 2017)
* Medical error
* “Deviations from the process of care, which may or may not result in harm.
* When planning or executing a procedure, the act of omission or commission that contributes or may contribute to an unintended consequence.”

Rodziewicz, Houseman and Hiskind, 2022

Latent error

* “accidents waiting to happen”

Lack of equipment maintenance or inaccurate installation

* Process design errors
* Negligent event
* “Failure to meet the reasonably expected standard of care of an average, qualified healthcare worker looking after a patient in question within similar circumstances. For example, the healthcare worker may not check up on the pathology report which led to a missed cancer or the surgeon may have injured a nerve by mistaking it for an artery.”
* Rodziewicz, Houseman and Hiskind, 2022
* Never event/Red flag rules
* Error reporting methods
* Error prevention
* “blame culture” – psychological effects on providers such as fear or reporting, shame, guilt
* By not reporting, the errors are more likely to continue.
* Reporting increases shame and guilt for some providers.
* Fear of legal ramifications
* SO, how can we prevent or reduce errors in the first place?

Culture shift

* Education strategies: completing computer-based training vs. hands on learning

Prevention strategies: stand down before procedures to ensure correct body part is marked as well as the correct side of the body

* Preventable reasons for error
* Joint Commission Goals

Creating a culture of safety video

* Annie's Story: How A System's Approach Can Change Safety Culture – YouTube
* Examples of medical errors
* A physician ordered MBSS on an unresponsive patient without seeing them at bedside. When transport came to pick up the patient, a medical response team alert was called. The patient was placed on BiPap and transferred to ICU.
* When I called the physician to tell them the test could not be completed, he questioned WHY. I explained that the patient needed to be:
* 1. MEDICALLY STABLE
* 2. AWAKE/ALERT
* 3. ABLE TO COMMUNICATE (non verbal or verbal communication)
* He had NO IDEA that our patients needed to be AWAKE; he did not see “what difference that makes”.
* Examples continued
* On the same weekend, two different patients on the same unit:
* 1. Large bore NG tube was placed instead of SBFT/Dobhoff; when the chest xray was completed, the tube was in the R lung with a guidewire visible that is not part of the NG tube, but a part of the Dobhoff tubing. The chest xray sat overnight, with not one person who saw it questioning it.
* 2. SBFT/Dobhoff placement was completed. Chest xray for verification/placement revealed it was in the lung. Tube feedings were initiated per the physician and the patient wound up with “aspiration” pneumonia. Was this a true “aspiration” due to dysphagia?
* More examples
* Outpatient came in for a MBSS. He began to share his story:
* He had a history of oral cancer and had completed a minor surgical resection/radiation. Was doing well, but started to feel like something was “off” when he was chewing. He went back to the ENT and his oncologist, both successfully treating him before. They both told him it was sensation changes and never did any imaging. The ENT “looked” in his mouth and told him “everything looks fine”. 3-4 months passed and the patient went in for routine dental cleaning. His dentist started asking him if he felt the “growth” on the base of his tongue. The dentist referred him back to ENT. The patient decided he would seek a different ENT. Turns out he had stage 3 lingual cancer with parotid involvement. Treatment was initiated and the tumor was gone by the time I saw him.
* Nursing error
* On the same weekend:
* 2 different patients had routine labs drawn while in acute care. The tourniquet was left on overnight. Both patients complained of pain/swelling after. Both were confirmed to have deep vein thrombosis (DVT).
* This was preventable. There are already steps in place/processes that were not followed.
* “Homemade” mixtures during MBSS

Dr. Bonnie Martin-Harris and colleagues

* “Currently, Varibar (Bracco Diagnostics Inc.) is the only Food and Drug Administration–approved contrast agent available in the United States that is specifically indicated for the MBSS (VARIBAR HONEY, 2018; VARIBAR NECTAR, 2018; VARIBAR PUDDING, 2016; VARIBAR THIN HONEY, 2018; VARIBAR THIN LIQUID, 2019). Varibar was designed with the most suitable radiodensity for fluoroscopic evaluation of the oropharyngeal region and formulated such that it does not coat the mucosal lining of the pharynx (Robbins et al., 2002).”
* We don’t have evidence to prove what happens to the barium suspension if we add something else.

Root Cause Analysis

* Why?
* Breaks down the “holes” in the system.
* More importantly, participants need to understand the work being done.
* Identifies the problem.
* Uses 5 WHYs
* Fishbone diagram
* How to use the 5 WHYs
* Identify the problem
* Why did it happen?
* Why?
* Why?
* Why?
* Why?
* This identifies countermeasures/solutions.
* Using the 5 Whys Worksheet - YouTube
* Fishbone Diagram
* Why A Fishbone Diagram Can Help Solve Risk And Quality Problems – YouTube
* How to empower yourself and your patients
* 1. Provide education – give the patients and their families/caregivers the name of the diagnosis within our scope of practice (aphasia, dysarthria, cognitive linguistic disorder, pediatric feeding disorder, etc.)
* 2. Seek out education for yourself and your professional practice
* 3. Review your consumer educational materials – health literacy – only ~12% of adults in the U.S. are considered “highly proficient” in medical terminology
* Health Literacy
* Health Literacy Universal Precautions Toolkit, 3rd Edition | Agency for Healthcare Research and Quality (ahrq.gov)
* Medical jargon

Use of medical jargon

Avoid overuse of “medical words”

Don’t just give the diagnosis! Explain in everyday terms what that means.

* “Sometimes you might notice your grandma can’t find the right word. That is called aphasia. She can understand what you are saying; but sometimes she knows the right word to say, but it gets stuck or disappears from her memory before she can say it.”

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